Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: JOHN S. PARKER D C 4030 N BELTLINE ROAD IRVING TX 75038-5043	MFDR Tracking #: M4-11-1263-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: NETHERLANDS INSURANCE COMPANY Box #: 19	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Table of Disputed Services: "Medical Fee Guideline MAR."

Amount in Dispute: $1,231.00

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This medical dispute concerns reimbursement for an EMG/NCV accomplished on June 14, 2010. The carrier submits that all fee reductions were made in accordance with the applicable fee guidelines. The carrier notes that preauthorization was not obtained for the service underlying the disputed charges. In addition, the rendering provider is not eligible to perform the service billed. The treatment is outside of the provider's scope of practice. In box 31, on the billing form, John Parker, D.C. is identified as the physician, and yet he is not the provider who performed the professional reading of the study and may not bill for the whole component for each CPT code on the bill. No reimbursement is due."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
06/14/2010	CPT code 95903	Not Applicable – Preauthorization Not Obtained	$246.00	$0.00
06/14/2010	CPT code 95904	Not Applicable – Preauthorization Not Obtained	$181.00	$0.00
06/14/2010	CPT code 95934	Not Applicable – Preauthorization Not Obtained	$185.00	$0.00
06/14/2010	CPT code 95861	Not Applicable – Preauthorization Not Obtained	$574.00	$0.00
06/14/2010	CPT code 95869	Not Applicable – Preauthorization Not Obtained	$45.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §134.600 sets out the fee guidelines for the reimbursement of workers' compensation non-emergency health care requiring preauthorization provided on or after May 2, 2006.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 08/11/2010 noted claim reduction codes:
   - 150 — Payer deems the information submitted does not support this level of service. $0.00.
   - 185 — The rendering provider is not eligible to perform the service billed. $0.00
   - 197— Precertification/authorization/notification absent. $0.00
   - 851-100— PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION. TREATMENT RENDERED IS IN EXCESS OF THE STATE SPECIFIED TREATMENT GUIDELINES (ODG) UMD RECOMMENDS $0.00
   - 856-115— THE RENDERING PROVIDER IS NOT ELIGIBLE TO PERFORM THE SERVICE BILLED. THE PROVIDED TREATMENT/SERVICE IS OUTSIDE OF THE PROVIDER'S SCOPE OF PRACTICE. UMD RECOMMENDS $0.00.

   Explanation of benefits date 10/18/2010 noted claim reduction codes:
   - 193 — Original payment decision is being maintained. The claim was processed properly the first time.
   - 197— Precertification/authorization/notification absent. $0.00
   - 851-100— PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION. TREATMENT RENDERED IS IN EXCESS OF THE STATE SPECIFIED TREATMENT GUIDELINES (ODG) UMD RECOMMENDS $0.00
   - 901— RECONSIDERATION NO ADDITIONAL PAYMENT. ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THS CLAIM WAS PROCESSED PROPERLY.
   - BILL NOTES: THE RENDERING PROVIDER IS NOT ELIGIBLE TO PERFORM THE SERVICE BILLED. THE PROVIDED TREATMENT/SERVICE IS OUTSIDE OF THE PROVIDER'S SCOPE OF PRACTICE. FURTHERMORE, THE PROVIDER ON BOX 31 DID NOT PERFORM THE PROFESSIONAL READING OF THE STUDY AND MAY NOT BILL FOR THE WHOLE COMPONENT FOR EACH CPT CODE ON THIS BILL.

Issues

1. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Tex. Admin. Code §134.600?
2. Did the requestor perform medical treatment/services outside of their scope of practice?
3. Is the requestor entitled to reimbursement?

Findings

1. Texas Labor Code Section 413.014(b) states "the insurance carrier is not liable for those specified treatments and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the commission." 28 TAC §134.600(c)(1)(B) states "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any health care listed in subsection (p) of this section was approved prior to providing the health care." 28 TAC §134.600(p)(8) requires preauthorization for "unless otherwise specified in this subsection, a repeat individual diagnostic study…(A) with a reimbursement rate of greater than $350 as established in the current Medical Fee guideline; or (B) without a reimbursement rate established in the current Medical Fee Guideline." Review of the submitted documentation finds that the Requestor did not submit documentation to support preauthorization approval was obtained prior to providing the services in dispute in accordance with 28 TAC §134.600.
2. y that is statutorily required to define the scope of practice of a particular type of medical license. Carriers should not deny payment of a medical bill based on scope of practice interpretations.
3. Review of the submitted documentation finds that the Requestor did not submit documentation to support preauthorization approval was obtained prior to providing the services in dispute in accordance with 28 TAC §134.600. Therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature	Medical Fee Dispute Resolution Officer	**02/18/2011** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.